

**TEXAS PULMONARY & CRITICAL
CARE CONSULTANTS, P.A.**

Pulmonary and Critical Care Specialists

SLEEP CONSULTANTS, INC.

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Comprehensive Care of Sleep Disorders: Diagnosis, Treatment, Follow-up, Education, Research

PATIENT SELF-REFERRAL

Date: _____

Have you had prior sleep testing? – YES / NO If yes, when and where: _____

Sleep-related diagnosis(es): _____

Patient Information:

Last Name: _____ First Name/Middle Initial: _____

Address: _____ City/State/Zip: _____

Sex: M F Marital Status: M S D W

SS#: _____ DOB: _____

Place a check next to the best phone number to call, so we can contact you to make your appointment.

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Other Phone: _____

Best time to call: _____

Employer: _____

Primary Care Physician: _____

PCP Phone: _____ PCP Fax: _____

Other physicians involved in your health care: _____

Primary Insurance Policy:

Insurance Co. _____ ID No. _____ Group No. _____

Name of Insured _____ Relationship to patient _____

Insured's Birth Date _____ SSN _____ Sex: M F

Claims Mailing Address _____

Phone No. _____

Secondary Insurance Policy:

Insurance Co. _____ ID No. _____ Group No. _____

Name of Insured _____ Relationship to patient _____

Insured's Birth Date _____ SSN _____ Sex: M F

Claims Mailing Address _____

Phone No. _____